This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate as described in Section III C of this plan, with the exception of inflation. No inflation adjustment will be made to the interim rates for the first six (6) months cost. Payment for the first six months will be retrospectively adjusted to actual costs not to exceed the standards. Effective on the first (1st) day of the seventh (7th) month of operation, a new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan.

The Medicaid agency will determine the percent of Level A Medicaid patients served for a replacement facility or a change of ownership, using the most recent twelve months of data (See Page 15, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS Aries report to establish rates.

3. Payment determination for a change in ownership through a lease of fixed assets:

In the event of a lease of fixed assets between unrelated parties, the new operator (i.e., lessee) will receive the prior operator's rate (i.e., lessor) for the first six full calendar months of operation. For a lease effective on October 1, the State agency will determine the new operator's rate based upon the prior year's cost report filed by the prior operator on January 1. The new operator's rate for the first six full calendar months of operation will not be affected by any subsequent audits of the prior operator's cost report which was used to set the rate. In the event that the initial six full calendar months rate period crosses over into a new rate setting period effective October 1, the new operator will be entitled to receive a rate increase based upon the industry allowed inflation factor, plus any industry wide approved add on, if applicable.

For clarification purposes, we intend to use the prior operator's most recently filed and available FYE September 30 cost report to calculate the new operator's rate effective October 1 of each rate cycle during the initial six full calendar month rate period. Depending upon which most recently filed cost report is available will dictate

the method used to determine the October 1 rate during the initial six full calendar month rate period (i.e. the October 1 rate during the initial six full calendar month rate period will be the prior owner's September 30 rate inflated, or the October 1 rate that the prior owner would have received if no change of ownership had taken place).

Effective the seventh month of operation, the new operator will be entitled to a new rate based upon his actual cost. The rate calculation for the new operator, based upon his actual costs, will be made in accordance with the rate setting method as described under Section III C of this plan. The actual cost report that will be filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30, provided that this time period includes at least six full calendar months of operation. In other words, if the lease is effective between October 1 and March 31, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends on September 30. If the lease is effective between April 1 and September 30, the cost report filed by the new operator will cover the period which begins with the effective date of the change in ownership and ends after six full calendar months of operation by the new operator. This cost report will be due within ninety (90) days after the end of the cost reporting period; however, a thirty (30) day extension can be granted for good cause. This cost report will determine a rate which will be effective retroactive to the new operator's seventh month of operation.

4. Rate determination for a facility in which temporary management is assigned by the state agency to run the facility:

In the event of the Medicaid agency having to place temporary management in a nursing facility to correct survey/certification deficiencies, reimbursement during the time in which the temporary management operates the facility will be based on 100% of total allowable costs subject to the allowable cost definitions set forth in this plan, effective October 1, 1990. These costs will not be subject to any of the cost standards as reflected on page 4 of the plan. Capital reimbursement will be based on historical cost of capital reimbursement in lieu of the Medicaid agency's current modified fair rental value system. Initial reimbursement will be based on projected costs, with an interim settlement being determined once temporary management files an actual cost report covering the dates of operation in which the facility was being run by the temporary management.

k) Speech and hearing services as described in 42 CFR §483.430(b)(1) and (b)(5)(vii).

l) Food and nutritional services as described in 42 CFR §483.480.

k) Speech and hearing services as described in 42 CFR §483.430(b)(1) and (b)(5)(vii).

l) Food and nutritional services as described in 42 CFR §483.480.

m) Safety and sanitation services as described in 42 CFR §483.470(a), (g)(3), (h), (i), (j), (k), and (l).

n) Physician services as described in 42 CFR §483.460(a).

Any service (except for physician services) that is required of an ICF/MR facility that is reimbursable under a separate Medicaid program area must be billed to the respective program area. Any costs of this nature cannot be claimed in the Medicaid cost report.

4. Interim reimbursement rates for ICF/MR facilities will be calculated based upon cost projections submitted by the South Carolina Department of Disabilities and Special Needs for the fiscal year in which the rate is to be set. This will be done in order to avoid large year end final cost settlements and improve the cash flow of the participating ICF/MR facilities.

5. The Medicaid Agency will not pay more than the provider's customary charge except public facilities that provide services free or at a nominal charge. Reimbursement to public facilities will be limited in accordance with 42 CFR §447.271(b).

H. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.

B) The rate excludes the cost associated with therapy services.

C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

I. Intensive Technical Services Reimbursement

An enhanced rate of $180 per patient day may be available for nursing facility recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). Effective October 1, 2003, this rate will be $188. This rate was determined through an analysis of costs of 1) a small rural hospital located in

South Carolina who would set up a small ward to provide this level of service and 2) contracting with an out-of-state provider which has established a wing in a nursing facility to deliver this type of service. This set per diem rate will represent payment in full and will not be cost settled. Providers receiving payment for intensive technical services patients will be required to step down cost applicable to this nonreimbursable cost center in accordance with item I(C) of this plan, upon submission of their annual cost report.

J. Essential Public Safety Net Nursing Facility Supplemental Payment

For nursing facility services reimbursed on or after January 1, 2002, qualifying Medicaid nursing facilities shall receive a Medicaid supplemental payment (in addition to the per diem payment). These payments will ensure the continued existence and stability of these core providers who serve the Medicaid population. The qualifications, upper payment limit calculation, and payment methodology are described below.

Qualifications

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

a) The nursing facility is a non-state owned public nursing facility;
b) The nursing facility is located in the State of South Carolina;
c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

and one of the following criteria:

(i) The nursing facility is hospital based; or
(ii) The nursing facility is leased and operated by a hospital; or
(iii) The nursing facility's total licensed beds is in excess of 300 beds.

(2) Upper Payment Limit Calculation

The upper payment limit effective January 1, 2002 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned public nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the most recently completed state fiscal year (i.e. July 1 through June 30) prior to the effective date of the plan amendment. The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (less coinsurance days) paid to the nursing facility during the most recently completed state fiscal year in order to allocate the Medicaid days across the 44 Medicare RUG categories.

d) Each qualifying Essential Public Safety Net nursing facility's supplemental payment will be calculated by taking the upper payment limit pool as described in J(3)(c) and multiplying by each Essential Public Safety Net nursing facility's percentage of unreimbursed UPL cost to total unreimbursed UPL cost of the Essential Public Safety Net nursing facilities.

The total payments made to the licensed South Carolina non-state owned public nursing facilities that contract with the South Carolina Medicaid Program, including the Essential Public Safety Net nursing facility supplemental payments, will not exceed the aggregate Upper Payment Limit amount for the non-state owned public nursing facilities. Additionally, the Essential Public Safety Net nursing facility supplemental payments will not be subject to the lower of costs or charges limitation.

The Essential Public Safety Net Nursing Facility Supplemental Payment Program will sunset effective July 1, 2005. However, in the event that Federal Upper Payment Limit Policy should permit the continuation of supplemental payment programs that allow providers to receive reimbursement in excess of cost on or after July 1, 2005, the South Carolina Department of Health and Human Services reserves the right to reinstate this payment provision at its discretion.

K. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

L. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section IV of this attachment.

M. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except public facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.

2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

PROVIDER NAME:
PROVIDER NUMBER:
REPORTING PERIOD: 10/01/01 through 09/30/02 DATE EFF. 10/1/2003

		MAXIMUM BED DAYS:	0
		PATIENT DAYS INCURRED:	0
PATIENT DAYS USED:	0	ACTUAL OCCUPANCY %:	0.00
TOTAL PROVIDER BEDS:	0	PATIENT DAYS @	0.96 0
% LEVEL A	0.000		

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR 4.70%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES				0.00
REIMBURSEMENT RATE				0.00

SC: MA 03-014
EFFECTIVE DATE: 10/01/03
RO APPROVED: MAY 26 2004
SUPERSEDES: MA 02-006